POSITION PAPER ON ADAPTATION OF THE DSAT MODEL DURING COMMUNITY IMPLEMENTATION

BACKGROUND

In August 2000, Jamieson, Beals, Lalonde and Associates (JBL) Inc. was contracted by the State of Maine, to develop the series of treatment services (screening and assessment instruments, treatment curricula, training manuals, implementation guidelines, treatment monitoring protocols, and an evaluation framework) required by the Maine Office of Substance Abuse (OSA) in order to implement a Differential Substance Abuse Treatment system.

The DSAT implementation approach is based on a "continuum" of assessment and treatment services that extends across the entire substance abusing offender population in Maine. DSAT has links to the Adult Drug Treatment Courts, as well as prison-based, transitional, and community based services. This "Position Paper" exclusively concerns the adaptation of the DSAT system during the community phase of implementation (i.e., Drug Court and Community Corrections).

Development History

The history of the Differential Substance Abuse Treatment (DSAT) system can be traced to research and development that took place between 1997 and 1999 by the Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services — Office of Substance Abuse (OSA). The best overview of the early development of the DSAT is located in the June 1999 report, *Differential Substance Abuse Treatment (DSAT) Model.* OSA was responsible for managing the research and development conducted on the DSAT model. The foundation for the implementation of the DSAT system is based on the research and clinical principles that were first articulated in the 1999 DSAT Model report.

OSA has taken great care to adhere to the standards established in the DSAT Model report as the services have been developed and implemented. The first phase of the DSAT service contract focused on the design of an entire treatment system for Adult Drug Court and Community Correction clients. The standards for implementing the DSAT community system have recently been presented in the DSAT Implementation Manual as well as in the core DSAT Treatment Manuals.

Programming Levels

Offenders are directed into treatment based on an assessment of risk/need whereby more intensive services are reserved for offenders who are at the highest risk for re-offending. The original plan was to direct offenders assessed with moderate dependence into a Level 3 intervention (which consists of ten 3-hour intensive, and twelve 2-hour maintenance sessions) while offenders assessed with substantial dependence were to be directed into a Level 4 intervention (which consists of fifteen 3-hour intensive, and twenty-four 2-hour maintenance sessions).

The Adcare Educational Institute is the organization responsible for managing the "day to day" implementation of the DSAT system in the community under the supervision of OSA. In recent months it has become apparent to OSA and Adcare that practical constraints mitigate against delivery that fully complies with the original plans to offer separate DSAT services at Level 3 and 4. As a result, OSA and Adcare have recommended a number of interim modifications to the DSAT model.

OBJECTIVES AND CAVEATS

The objective of this paper is to

- respond to the proposed modifications, describing the extent to which JBL Inc. thinks the system can be adapted while still preserving essential elements of program integrity;

- provide implementation advice and guidance, to help ensure that interim products and services adhere to the DSAT concepts as much as is practicable.

Having said that however, we must stress the following:

- Empirical evidence supports the highly differentiated treatment system represented by DSAT, as designed. So adaptations we endorse here must be viewed as potentially less efficacious than the "ideal" system, but still more effective and desirable than adapting it in other ways.

- Our understanding is that the "adapted community DSAT system " is an interim measure only. Its purpose is to ease implementation, and within a nine to eighteen-month period, the adapted system will be replaced by the original DSAT system.

THE CONSTRAINTS, AND PROPOSED RESPONSES TO THEM

OSA and Adcare have identified the prime problem driving implementation concerns in the community as low numbers of referrals into treatment. The DSAT system features different treatment programs for offenders screened at different levels, based on both their level of substance use dependence and risk for recidivism. Because the community population of Maine is highly regionalized, it appears that assembling groups with the proper number of participants in a timely fashion is highly unlikely.

In response, OSA has proposed a series of adaptations to the community phase of DSAT implementation.
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Key among these are:

- Combining some levels of treatment (cognitive behavioral) programming (where a key feature of the DSAT system is *differentiated* treatment for offenders with different levels of dependence and criminal risk);

- "Opening up" the Motivational Enhancement Treatment (MET) program (which in the DSAT system has been designed to be delivered in an incremental fashion with attention to group dynamics);

- Developing a brief Pre-Treatment intervention that targets offenders who have completed the MET program prior to entering a community treatment program.

In addition, there has been considerable concern about the advisability of leaving those relatively few male offenders rated at Level 5, (the most severe level of substance abuse dependence) out of the DSAT system. (The original assumption when designing the system, was that treatment of male Level 5 offenders would be referred to existing community residential facilities, while a small number of female Level 5 offenders would participate in the Level 4 – programming. For this reason, all of the program manuals for women are designated as Level 4+, rather than simply Level 4.)

Each of these modifications or concerns is addressed in a dedicated section below.

COMBINING DIFFERENT LEVELS OF PROGRAMMING

Combining Levels 3 and 4.

The OSA proposal is to partially combine offenders in Levels 3 and 4 in community treatment programming. The services would be delivered in the following manner during the intensive and maintenance phases of treatment:

- Combine Level 3 and 4 offenders during the first 9 sessions of the intensive phase of treatment (which are common to Levels 3 and 4). For the remainder of the intensive phase offenders will receive separate treatment. DSAT facilitators will provide orientation to Level 3 and 4 participants so that everyone understands how they will progress throughout the treatment phases.

- Combine Level 3 and 4 offenders during the maintenance phase of treatment (which features 12 sessions for Level 3 and 24 sessions for Level 4). Level 3 and 4 offenders would be combined during the first 10 sessions of maintenance, but then each level would go on separately to complete its remaining sessions of the maintenance phase of treatment. (Note that only 10 of the 12 Level 3 sessions could be delivered to Level 3 and Level 4 offenders combined, since the last two sessions of each level of programming consist of the administration of a Drug Taking Confidence Questionnaire, and then a graduation ceremony).

- This partially combined approach provides the same number of treatment sessions to Level 3 and 4 offenders (e.g., Level 3 – 10 intensive and 12 maintenance and Level 4 – 15 intensive and 24 maintenance sessions) called for in the original design. The only design deviation is that offenders are combined during periods of the treatment.

Our response to the proposed modification is set out below.

- JBL views combining offenders in treatment as a realistic treatment solution to deal with the low referral base.

- The offender's nature and extent of substance abuse and criminal behavior tends to be in a similar range for these types of offenders.

- Offenders continue to receive more intensive treatment services based on their assessed level of dependence/criminal risk.

- To lessen the impact of combining offenders during the intensive and maintenance phases of treatment, DSAT facilitators should:

    - Carefully document the offender's treatment needs and criminal histories (Level 3's and 4's) during the assessment process; and

    - Ensure that responses are solicited from offenders assessed at both Level 3 and Level 4 during the delivery of the community treatment groups in order to achieve balanced group participation.

Provide Programming to Offenders Assessed at Level 5

The Community DSAT system targets offenders with moderate to substantial levels of dependence with the Level 3 and 4 interventions. According to the original plan, DSAT facilitators were to be trained to refer offenders assessed at a "severe" level of dependence (Level 5) to more intensive community residential treatment given that DSAT was not designed for this particular group of offenders.

As an interim measure prior to the time that these adaptations to the community model were proposed, DSAT facilitators were instructed to allow a maximum of one or two Level 5 offenders into a Level 4 intervention. The rationale for this was that:

- Allowing this small number of Level 5 participants into Level 4 treatment is not likely to disrupt the group dynamics and thus will probably not have a negative impact on Level 4 offenders

- In addition, Level 5 offenders can have access to even more intensive programming, since facilitators will have the option of referring these offenders into ongoing community treatment once the DSAT intervention is completed.

This approach to handling Level 5 offenders must now be re-considered in light of the mixed Level 3/Level 4 composition of groups which will come about as a result of the proposed adaptations. Groups consisting primarily of Level 4 offenders along with a small percentage of Level 5 offenders are NOT perceived as problematic. However, groups that include Level 3 offenders along with Level 5 offenders ARE likely to be problematic.

Under no circumstances should Level 5 offenders be allowed to participate in groups that also include Level 3 offenders. There is too great a difference in the problems and perspectives of offenders assessed at these levels, and too high a probability that Level 3's being intimidated by the Level 5 offenders.

In the event that a treatment group is assembled where every offender assessed at substantial level of dependence (i.e., Level 4) then "case by case" decisions can be made to include up to 20% of the participants at the severe level of dependence (i.e., Levels 5). There are no exceptions to include more than 20% of severe offenders with an *exclusive group* of Level 4 offenders. This should mitigate against the likelihood of the Level 5 offenders dominating the program – something we see as a probable development if they comprise a larger percentage of the group overall.

The best option remains referring offenders with severe dependence into more intensive community residential services.

'OPENING UP' MET

The OSA/Adcare proposal is to ensure that offenders can enter into the MET services in an "open" fashion. In other words, offenders could join a MET group already in progress without the need to start with group session one and proceed to group session four. The proposal does not call for any change in the content or number of individual and group MET sessions.

This proposal to deliver the MET sessions in an "open" fashion is consistent with the guidelines presented in *the Motivational Enhancement Treatment (MET) Manual – Institutional and Community Volume* (Volume 1: 2001 – Office of Substance Abuse).

Here are some of the key original MET delivery assumptions, which drive our response to the proposed "opening up" of MET:

- MET is delivered to men and women separately;
- The number of MET sessions (individual and group) increases as you move from low intensity programming (i.e. Level 3) to higher intensity programming (Level 4);
- At Level 3, there are 2 individual sessions and 3 group sessions;
- At Level 4, there are 2 individual sessions and 4-5 group sessions;
- Once service delivery begins, at least one MET session can be delivered each week. More frequent delivery is allowed if time and resources permit.
- In addition, the MET manual contains recommendations for the sequence and content of the MET delivery. The manual states (page 7):

"*There is no fixed sequence for delivering the individual and group MET sessions. DSAT facilitators can select from the menu of options in the MET manual to meet the delivery requirements for each group."*

Other relevant recommendations in the manual include:

- that DSAT facilitators conduct an Initial and Mid-Treatment MET individual session.

- the following sequence for group delivery: Both Sides of Change; Change/Not Change; Drugs on Trial; and Pathways Forward. In addition, there is another optional session called Pathways Forward.

Response to Proposed Modification

There is enough flexibility in the existing MET individual and group sessions to offer an "open group" intervention. The group (MET) sessions can be delivered using an "open" format. There are two individual (MET) sessions -- the "Initial" session and the "Mid-Treatment" session. Facilitators must ensure that all participants entering into the group (MET) sessions have received the Initial (MET) session on a one-to-one basis prior to entering the group. This approach allows facilitators to conduct the "Initial" individual sessions whenever new candidates are accepted into group treatment. Facilitators are also required to schedule a second individual MET session with all participants at the mid-point in their group (MET) delivery.

For the group sessions, we recommend that every effort be made to follow the recommended sequence of delivery, but that offenders can be asked to return for additional group MET sessions if they miss any of the first 3 sessions.

PRE-TREATMENT PROGRAM

We agree that concerns about long waits for the start of intensive programming are justified. We endorse the concept of Pre-Treatment sessions to bridge the gap. We have already started work on a program which:

- will comprise six stand-alone sessions. By stand-alone, we mean there will be no pre-determined sequence of delivery, and that participants who take one session but not another, will not find themselves adrift because of skills or context conveyed in a session they did not attend;

- has one to one-and-a-half hours of structured programming with a half-hour devoted to more open discussion;

- will be psycho-educational in nature but will include skill development;

- will build on the climate of motivation engendered by MET (by using methods and approaches which stress both fun, and personal meaning). This should build receptivity to both the intensive and maintenance programs;

- start to develop familiarity and skill with key methods used in both intensive and maintenance programs;

- is designed to be an integral link to the overall DSAT objective of motivating and engaging offenders in skill development and practice.

Other Design Parameters

- Group Size: As with all other program components, group size is a key design factor. Because quality group dynamics are difficult to achieve with larger groups, group size should be limited to no more than 10 participants. The Pre-Treatment sessions were designed with the expectation that between four and ten participants would attend (Delivery to groups of 3 will be viable, but far less desirable).

- Gender: The language used in the sessions will be suited for delivery to both groups of men, and to groups of women. Because there are likely to be some preferred delivery approaches based on gender, those written into the sessions are geared to groups of men. The introduction to the program will provide specific instructions on how to adapt the program to groups of women - only offenders. We feel very strongly that no mixed-gender groups should be considered. The potential for reduced efficacy and even harm in the case of women offenders, is too great to consider this a viable way to increase group size.

TRAINED FACILITATORS AS OBSERVERS

In the event that trained facilitators are not in practice due the low number of referrals to treatment, we endorse observation as a good method of keeping facilitators not directly involved in delivery “in touch” with the program, but note the following:

- It is essential that all parties recognize that the observer’s role is non-participatory. In order to not intrude upon or change group dynamics, observers must not speak or participate in a session in any way.

- This approach makes starting the process of monitoring the quality of the facilitation skills of those doing delivery an extremely high priority, since they will be serving as role models for others. One of the prime objectives in monitoring will be to ensure that any guidance required to help program deliverers function as facilitators (and not as counselors) is provided.